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DONNA MATHEWS

UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF CALIFORNIA

DONNA MATHEWS,  
Plaintiff,

vs.

PAN AMERICAN LIFE INSURANCE  
COMPANY; and DOE 1 through Doe 20,  
Inclusive,

Defendants.

No. C 07-02757 SBA

[PROPOSED] ORDER DENYING  
MOTION FOR SUMMARY  
JUDGMENT

Date: June 10, 2008  
Time: 1:00 p.m.  
Cttrm: 3

The Motion of Defendant Pan American Life Insurance Co. for Summary Judgment, or, Alternatively, Partial Summary Judgment, came on regularly for hearing on June 10, 2008, in Courtroom 3 of the above-entitled Court, the Hon. Sandra Brown Armstrong, presiding. Having considered the evidence submitted and the arguments of counsel, the Court rules as follows:

**I. BACKGROUND**

Plaintiff Donna Mathews purchased long term disability insurance from Defendant Pan American Life Insurance Company ("Pan American") in 1991. An important reason she bought this policy is that it provides vocational rehabilitation benefits. As a dental hygienist, Plaintiff was concerned that she might sustain a disability that prohibited her from working the

1 awkward position that her job required. Plaintiff wanted to be able to retrain into a new profession  
2 if that happened, and looked upon Pan American's insurance policy as her bridge to a new career  
3 in the event that she could not longer work as a dental hygienist.

4 In November 2005 she fell off a ladder and was injured. Her injury caused her to be  
5 disabled from her occupation of dental hygienist, giving rise to Pan American's obligation to  
6 provide policy benefits.

7 Pan American failed at the inception of the claim to determine which policies covered  
8 Plaintiff and what benefits those policies provided. Instead, it ignored its obligation to the Plaintiff  
9 and overlooked the fact that Ms. Mathews was entitled to monthly benefits of \$2700 per month,  
10 incorrectly representing to her that she was only entitled to benefits of only \$2200 per month. Pan  
11 American indexed all policies under the insured's name, birth date and social security number.  
12 Thus, Pan American had a computer system that would have permitted the claims examiner to  
13 triple check for benefits. If a claims examiner utilized that system, he could be assured of finding  
14 all applicable policies, even if sloppy data entry by Pan American had resulted in a typographical  
15 error in one of the fields. This system does not work unless claims personnel are trained to use it,  
16 and unless policies exist requiring claims personnel to use the system correctly each time a claim  
17 arrives. Pan American, however, provides neither training nor policies to its claims personnel. In  
18 fact, all of its disability claims are adjusted by someone with no prior disability claim experience.  
19 Defendant has not trained this person, or otherwise provided him with direction on how to handle  
20 those claims.

21 Pan American has no claims manual whatsoever for handling disability claims.  
22 Apparently recognizing that it is illegal under California law to operate an insurance company  
23 without a claims manual, Defendant engaged in a ludicrous effort to manufacture one during  
24 discovery. Pan American located a pamphlet that another company had written, and produced it  
25 in response to a request that it produce its claims manual. Upon examination at deposition, it  
26 quickly became clear that this pamphlet was never considered to be a claims manual, and was  
27 never used as one.

28 Months passed, and Plaintiff was underpaid her benefits. Pan American affirmatively

1 represented to Plaintiff that she was being paid in full. This representation was untrue. Although  
2 Pan American purportedly overlooked the third policy when it calculated the benefits it was  
3 required to pay Ms. Mathews, it did not overlook its premiums. Every month, Pan American  
4 withdrew a premium from the Mathews' bank account in connection with the third policy. In  
5 August 2006, Ms. Mathews noticed that Pan American was still withdrawing \$37.70 from her bank  
6 account each month. She wrote to Pan American about it, but Pan American ignored her. In  
7 September 2006, Plaintiff received an overdraft notice from her bank that was the result of Pan  
8 American withdrawing money from her bank account. Ms. Mathews telephoned the billing  
9 department at Pan American and demanded to know why money was being withdrawn from her  
10 bank account. The billing department explained to her that there was a third policy, that it was not  
11 being paid as part of her claim, but instead was being treated as though Ms. Mathews was not  
12 disabled. Money was being withdrawn to pay the premium on the third policy. Ms. Mathews then  
13 contacted the claims department, and they agreed to start paying Ms. Mathews the monthly benefit  
14 she had purchased.

15 After making only the first monthly payment, Pan American terminated Ms.  
16 Mathews' benefits in March 2006. Pan American has admitted that the only reason Pan American  
17 took this action was because the initial Attending Physician Statement contained a prognosis that  
18 suggested that Ms. Mathews might recover by March 2006. Prior to the time that Pan American  
19 cut off Plaintiff's benefits, it had received information from Plaintiff's doctor that showed that  
20 Plaintiff had not recovered and that her treating doctor had her out of work for several more  
21 months. This information did not affect the decision to cut off Plaintiff's benefits because Pan  
22 American's process is always to rely on the original Attending Physician Statement no matter  
23 what. Pan American did not investigate to determine whether Ms. Mathews had, in fact,  
24 recovered. It did not contact Ms. Mathews, her employer or her physicians. Such investigation  
25 would have been contrary to Pan American's stated business practice of relying exclusively on the  
26 initial Attending Physician Statement, regardless of any other evidence.

27 Shortly after it wrongfully terminated her monthly benefits, Pan American withdrew a  
28 full year of premiums from the Mathews' bank account. it should not have withdrawn any money,

1 since the policy provided for a waiver of premiums and Pan American had sent Ms. Mathews a  
2 letter on March 13, 2006 (just two days before cutting off her benefits) advising Ms. Mathews that  
3 Pan American had classified her as disabled and that all premiums were waived.

4 Pan American refused to pay benefits for about three months, from April through July  
5 2006, although it knew Ms. Mathews was not working and that her treating physicians had  
6 determined that she was disabled. Pan American had information in its files in March before it  
7 stopped paying benefits that showed that Ms. Mathews was still not working due to disability. It  
8 received further confirmations of this fact in April and May. Pan American obtained the records  
9 from Plaintiff's treating doctors, all of which it had received by May 23, 2006. On July 12, 2006,  
10 based on the information it had been holding for more than six weeks, Pan American resumed  
11 paying monthly benefits policy 1257-758 and on policy 1285-764.

12 When Pan American finally resumed benefit payments in July 2006, it began paying  
13 benefits 90 days in arrears. Pan American now acknowledges that it is obligated to make benefits  
14 payments current, and not to pay significantly in arrears as was done here. Pan American  
15 continued to pay benefits 90 days in arrears until just last month. On April 5, 2008, it finally  
16 brought the benefits current. The issue of Pan American's failure to make timely payments had  
17 arisen several times in this litigation, but Pan American required Plaintiff to endure a year of  
18 litigation before bringing her benefits current.

19 In 2008, Pan American even tried to cover up the fact that it was improperly paying  
20 Ms. Mathews in arrears. On February 7, 2008, Pan American sent EOBs of that date falsely  
21 indicating that Ms. Mathews was being paid current, when in fact she was being paid 90 days in  
22 arrears. This false representation was repeated the following month.

23 A primary reason Ms. Mathews purchased a policy from Pan American instead of  
24 some better known carrier was Pan American's agreement to provide rehabilitation benefits. As a  
25 dental hygienist, Ms. Mathews was concerned that her ability to hold the necessary awkward  
26 position required for many hours, or her ability to perform fine movements in the small workspace  
27 of a patient's mouth, could easily become compromised. She perceived the Pan American policy,  
28 providing five years "own occupation" disability benefits and funds for vocational rehabilitation, as

1 a potential bridge to a new career if she could no longer work as a dental hygienist. Both the policy  
2 and the accompanying literature made clear that Pan American would provide vocational  
3 rehabilitation benefits, and Ms. Mathews reasonably relied thereon.

4 The issue of Ms. Mathews' vocational rehabilitation first came up in March 2006.  
5 Dr, Eichbaum, one of Ms. Mathews' treating physicians, suggested to Ms Mathews that she should  
6 consider retraining in a completely different field. Ms. Mathews told Pan American about Dr.  
7 Eichbaum's recommendation in early April 2006. Pan American saw that recommendation when it  
8 came in, but did contact Ms. Mathews, her physicians or a rehabilitation expert on that subject  
9 because Pan American has a business practice not to tell the insured what benefits are available  
10 under a policy and not to process any benefits that the insured has not specifically requested.

11 On July 21, 2006, Ms. Mathews wrote to Pan American requesting vocational  
12 rehabilitation benefits. She told Pan American that she was already taking classes that were needed  
13 to gain admittance to nursing schools, and that she would be able to apply to nursing schools once  
14 she had finished those classes. On or about August 3, 2006, Pan American wrote back to Ms.  
15 Mathews asking for "a copy of her rehabilitation plans."

16 On August 23, 2006, Ms. Mathews wrote back to Mr. Jones, laying out her  
17 rehabilitation plans as best she could, explaining how important it was for her to return to the work  
18 force due to the personal and financial stress that her disability was causing, and pointing out that  
19 the rehabilitation benefit was "the primary motivation for my purchasing your company's coverage  
20 in the first place." The plans she described were in sufficient detail to permit Pan American to  
21 investigate her claim. Two days later, Pan American responded to Ms. Mathews' request by  
22 denying her claim for rehabilitation benefits without explanation.

23 Pan American always denies claims for rehabilitation benefits. It has never paid a  
24 single claim. The employee assigned to handle these claims has received no training or guidance at  
25 all as to how to handle claims for rehabilitation benefits. Pan American has supplied him with no  
26 written guidelines on the subject. His supervisor is likewise unknowledgeable. Pan American  
27 admits that it did not have sufficient information to deny the claim when it wrote the denial letter.  
28 It agrees that Pan American should have asked Ms. Mathews to provide further information rather

1 than denying her claim. In fact, it already possessed all of the information he needed to grant the  
2 rehabilitation benefits, or could have easily found the information in a matter of minutes on the  
3 internet. The evidence is clear that Plaintiff was entitled to this benefit.

4 Following Pan American's terse and cryptic denial of rehabilitation benefits, Ms.  
5 Mathews proceeded to complain to the California Department of Insurance and the Napa County  
6 District Attorney, listing the failure to provide rehabilitation benefits as one of the issues. In  
7 response to these complaints, Pan American wrote letters stating that: "The rehabilitation portion  
8 of the policies is an additional benefit that is disbursed at Pan American's discretion. The  
9 rehabilitation benefit is not, nor was it ever an entitlement for the insured." Following advice she  
10 received from the Department of Insurance, in October 2006 Ms. Mathews wrote to Pan American  
11 asking the following questions: "Can you tell me what would justify rehabilitation? Is there a  
12 company policy regarding rehabilitation? Do you ever approve this benefit or make exceptions,  
13 and could I make an appeal for this benefit?" Plaintiff received no answer to any of her questions  
14 for more than a month, so on November 27, 2006, she wrote to Mr. Jones asking him to respond  
15 to her questions. After Plaintiff insisted on a response, Pan American again denied her claim,  
16 without any further investigation, and with any real explanation.

17 Pan American engaged in numerous other acts that violated its insurance policy,  
18 California law, or just generally were oppressive and made Plaintiff's relationship more difficult,  
19 including failure to properly refund premiums, refusal to waive premiums as required by the  
20 policy, improper account, sending benefits in the wrong amount, providing confusing explanations  
21 of benefits, requiring Plaintiff to travel more than 100 miles for a medical examination, and  
22 generally treating her in a hostile and demeaning manner.

## 23 II. LEGAL STANDARD

24 On a Motion for Summary Judgment, the court must view the evidence in the light  
25 most favorable to the nonmoving party. Lopez v. Smith, 203 F.3d 1122, 1131 (9th Cir. 2000).  
26 The court must not weigh the evidence or determine the truth of the matter, but only determine  
27 whether there is a genuine issue for trial. Balint v. Carson City, 180 F.3d 1047, 1054 (9th Cir.  
28 1999). In insurance bad faith cases, an insurer is not entitled to a summary judgment where,

viewing the facts in the light most favorably to the insured, a jury could conclude that the insurer acted unreasonably. See Amadeo v. Principal Mut. Life Ins. Co., 290 F.3d 1152, 1161 (9th Cir. 2002); Hubka v. Paul Revere Life Ins. Co., 215 F. Supp.2d 1089, 1092 (S.D. Cal. 2002). The reasonableness of an insurer's claims-handling conduct is ordinarily a question of fact. Hangarter v. Provident Life & Accident Ins. Co., 373 F.3d 998, 1010 (9th Cir.2004).

### III. ANALYSIS

The First Cause of Action of the Complaint alleges three breaches of the insurance contract: failure to pay benefits in full; failure to refund all premiums per the policy; and failure to provide rehabilitation benefits. There is convincing evidence that Defendant breached the contract as alleged.

By its recent actions, Defendant has admitted that it failed to pay benefits in full. At the time the Complaint was filed, Defendant owed Plaintiff for 90 days of past due policy benefits. Each of the policies contain a provision that obligates Defendant to pay benefits current:

"When Proof of Loss has been received at our home office, we will:

**Pay all income payments then due;**

**Pay all future income payments monthly as they become due;**

**When our liability ends, immediately pay any balance due at that time."**

California law requires disability insurers to pay benefits current and not in arrears. Ins. Code § 10350.8. Defendant's failure to pay benefits current breached the contract.

In April 2008, after a year of litigation, Defendant finally acknowledged that it had breached the contract by paying the arrearage. While this voluntary unconditional payment reduces the amount of recoverable contract damages by the amount of payment, it does not affect the tort claims. Indeed, if anything, the recent payment of the past due benefits strengthens the bad faith case in that it demonstrates the how unreasonable Defendant had been in refusing to pay benefits up until now. Further, Defendant's payment failed to make Plaintiff whole, because Plaintiff had incurred attorney fees to force Defendant to make the payment. These fees constitute damages under the rule announced in Brandt v. Superior Court (1985) 37 Cal.3d 813.

The second category of breach of contract alleged in the Complaint stems from Defendant's failure to refund premiums as provided in the policies. As set forth above, Defendant

1 has consistently failed to account for or properly refund premiums to Plaintiff, in spite of  
2 Plaintiff's many requests and even in spite of inquiries from the California Department of  
3 Insurance. Defendant still has not refunded all of the premiums as required by the policies.

4 The third category of breach of contract alleged in the Complaint is the failure to pay  
5 the rehabilitation benefits provided by the policies. This is both the largest and most egregious  
6 breach of contract. The rehabilitation benefit was a significant reason Plaintiff purchased these  
7 policies. Plaintiff duly applied for the benefit, and was turned down without explanation. When  
8 she requested further clarification Defendant at first ignored her and later misrepresented its bad  
9 faith claims practices. Defendant made it eminently clear that there was nothing Plaintiff could say  
10 or do that would be convince Defendant to provide the benefits. She was left with no choice but  
11 litigation. Discovery has revealed that Defendant has no policy manual concerning rehabilitation  
12 benefits, no one with experience in vocational rehabilitation reviewing claims, never investigates  
13 claims that come in, never advises insureds that they might qualify for the benefit, and has denied  
14 every claim for rehabilitation benefits ever presented to it.

15 After a year of litigation, Defendant still has not acknowledged that Plaintiff is  
16 entitled to the rehabilitation benefit, although Plaintiff obviously qualifies for the benefit.  
17 Plaintiff's entitlement to the rehabilitation benefit is underlined by the fact that following  
18 Defendant's refusal to provide the benefit, Plaintiff applied to the California Department of  
19 Rehabilitation, which found that vocational rehabilitation was appropriate for her. The Department  
20 of Rehabilitation made its decision with no more information from Plaintiff than Defendant had at  
21 the time Defendant turned her down.

22 Plaintiff is entitled to damages for Defendant's breach of its contract to provide  
23 rehabilitation benefits. insurers are not relieved from their obligation to provide policy benefits  
24 merely because the insured has collateral contracts or relations with third persons which relieve  
25 him wholly or partly from the loss against which the insurance company agreed to indemnify him.  
26 Textron Financial Corporation v. National Union Fire Insurance Company of Pittsburgh, (2004)  
27 118 Cal. App. 4th 1061, 1077; Atmel Corp. v. St. Paul Fire & Marine Ins. Co., (N.D. Cal. 2006)  
28 430 F. Supp. 2d 984, 986. The public policy behind this rule is obvious. Absent such a rule, it

1 would be in the best interest of insurance companies to refuse to pay benefits in cases where the  
2 benefits might be available from the government. For example, health insurers could reject claims  
3 in the expectation that the claim would be covered by Medi-Cal. Under Defendant's theory of  
4 damages, if Medi-Cal paid the claim, the health insurer could not be held liable for damages. The  
5 rule that insurers must pay benefits according to their contracts is embodied in California Insurance  
6 Code § 10111.

7 Second, Defendant has admitted that it must pay the rehabilitation benefit regardless  
8 of whether Plaintiff found another source of funding. Defendant designated Cory Simon as its  
9 person most knowledgeable on its interpretation of the policy language governing the rehabilitation  
10 benefit. Simon testified that Defendant interprets the policy language of the Income Protection  
11 Policy to mean that Defendant may not offset rehabilitation benefits received from another source.  
12 In other words, Defendant understands that it has the obligation to pay policy benefits regardless of  
13 whether another source provides coverage. Thus, the decision of the Department of Rehabilitation  
14 to approve Plaintiff for nursing school is not relevant to damages.

15 Third, as a matter of law, the benefits provided by the Department of Rehabilitation  
16 are secondary to benefits available through private insurance. See Cal. Admin. Code tit. 9, § 7196  
17 and § 7197. The obligation of Defendant is primary, and Defendant may not escape its obligation  
18 by looking to the Department of Rehabilitation.

19 Fourth, the Department of Rehabilitation has not paid all of Plaintiff's expenses under  
20 the plan it approved. Plaintiff has past and ongoing expenses that Defendant should pay.

21 Finally, if Defendant had not breached its contractual obligation to provide  
22 rehabilitation benefits, Plaintiff would have attended the more expensive and better regarded  
23 Pacific Union College, which is nearer her home. Although Defendant was on notice that Plaintiff  
24 wanted to attend Pacific Union, Defendant declined to investigate whether Pacific Union was  
25 appropriate for Plaintiff's rehabilitation. Defendant's one sentence denial of Plaintiff's claim did  
26 not indicate that Defendant's denial was at all based on a refusal to allow Plaintiff to attend Pacific  
27 Union. Under these circumstances, Defendant has waived its claim, raised for the first time in its  
28 moving papers, that it would not pay the tuition at Pacific Union but would insist that Plaintiff

1 attend a public institution. See, e.g., Legarra v. Federated Mut. Ins. Co., 35 Cal. App. 4th 1472,  
 2 1486 (1995) holding that: "an insurer waives its right to rely on defenses that it has not specified in  
 3 its letter denying coverage, but which a reasonable investigation would have disclosed." Legarra  
 4 points out that this rule is grounded in the sound public policy that insurers need an incentive to  
 5 make a thorough investigation of claims. Here, by refusing to investigate Plaintiff's claim, by  
 6 refusing to tell Plaintiff what was defective about the claim she submitted, by refusing to allow  
 7 Plaintiff to appeal her claim, and by refusing to answer Plaintiff's questions about her claim,  
 8 Defendant waived any right (if it ever had one) to insist that Plaintiff attend only public colleges.

9         There is overwhelming evidence of bad faith here, Plaintiff's Second Cause of Action.  
 10 The implied covenant of good faith and fair dealing serves to prevent an insurer from impairing the  
 11 insured's right to receive the benefits for which she contracted. Egan v. Mutual of Omaha Ins.  
 12 Co. (1979)24 Cal. 3d 809, 818-809. Unreasonable withholding of policy benefits due the insured  
 13 gives rise to a tort cause of action for breach of the implied covenant. Gruenberg v. Aetna  
 14 Insurance Co. (1973) 9 Cal. 3d 566, 574. Withholding of benefits may take any of the following  
 15 forms: denial of benefits due (Mariscal v. Old Republic Ins. Co. (1996) 42 Cal. App. 4th 1617,  
 16 1623); discontinuing ongoing benefit payments (Morris v. Paul Revere Life Ins. Co. (2003) 109  
 17 Cal. App. 4th 966, 977); paying less than due (Neal v. Farmers Ins. Exch. (1978) 21 Cal. 3d 910,  
 18 921); or unreasonable delay in payment (Waller v. Truck Ins. Exch., Inc. (1995) 11 Cal 4th 1,  
 19 36). Pan American is guilty of all four forms of withholding benefits. It improperly denied the  
 20 rehabilitation benefit. It improperly cut off the ongoing monthly disability benefits in March 2006  
 21 without good cause. It unreasonably failed to determine how many policies Plaintiff had, and as a  
 22 result paid less than was due in monthly benefits for an extended period of time, and it underpaid  
 23 the refund of premiums due under the policy. It unreasonably delayed payment of three months of  
 24 disability benefits almost until now.

25         The denial of rehabilitation benefits demonstrates bad faith in several ways. Each of  
 26 the following is a wrongful act that provides evidence of bad faith.

27         Pan American has a business policy of never advising its insureds that they might be  
 28 entitled to rehabilitation benefits. California law requires the carrier to disclose "all benefits,

1 coverage, time limits or other provisions of any insurance policy issued by that insurer that may  
 2 apply." 10 Cal Admin Code § 2695.4. Pan American violated this rule when it failed to tell  
 3 Plaintiff that rehabilitation benefits might be available in April 2006 when Pan American first  
 4 received medical reports that rehabilitation might be appropriate. It has a business practice of  
 5 violating this rule, and violates it in the case of every policyholder to whom it applies.

6 Pan American does not have a claims manual that addresses how to handle  
 7 rehabilitation benefits. In fact, it does not have any claims manual at all. California imposes a  
 8 legal requirement on all carriers to have a claims manual, and requires that the manual include a  
 9 copy of California regulations regarding claims handling practices. 10 Cal Admin Code § 2695.6.  
 10 The same law also requires insurers to train claims personnel, another rule ignored by Defendant.  
 11 Further, the Unfair Claims Settlement Practices Act (Ins. Code § 790.03(h) requires insurers "to  
 12 adopt and implement reasonable standards for the prompt investigation or claims." Courts have  
 13 found that a statutory violation of the Unfair Claims Settlement Practices Act has evidentiary value  
 14 in a bad faith action, i. e., it tends to show a breach of the insurer's implied covenant. Estate of  
 15 Parker ex rel. Parker v. AIG Life Ins. (C.D. Cal 2004) 317 F. Supp 1167, 1171-2; Rattan v.  
 16 United Services Auto. Ass'n, 84 Cal. App.4th 715, 724 (2000).

17 The duty of good faith and fair dealing requires an insurer to act reasonably in  
 18 denying coverage. Shade Foods, Inc. v. Innovative Products Sales & Marketing, Inc. (2000) 78  
 19 Cal. App. 4th 847, 879. An insurer acts unreasonably in denying coverage where it fails to  
 20 reasonably investigate a claim. *Id.* at 879-80. "An unreasonable failure to investigate may be found  
 21 when an insurer fails to consider, or seek to discover, evidence relevant to the issues of liability  
 22 and damages." *Id.* at 880. Here, Defendant's failure to investigate was total. It did not even make  
 23 a pretense of investigation, and never does. As soon as Plaintiff told Defendant that she wanted to  
 24 rehabilitate into nursing by pursuing a degree at one of three Northern California colleges,  
 25 Defendant slammed the door in her face. The denial letter went out within forty eight hours. No  
 26 investigation whatsoever took place, nor does it ever. An insurer commits the tort of bad faith  
 27 when it denies payments to its insured without fully investigating the grounds for its denial.  
 28 Frommoethelydo v. Fire Ins. Exchange, 42 Cal. 3d 208, 215 (1986); Egan v. Mutual of Omaha

1 Ins. Co., 24 Cal. 3d 809, 818-19 (1979).

2 Following its initial denial of rehabilitation benefits, Defendant continued its bad faith  
3 refusal to investigate. In October 2006, Plaintiff asked Defendant what she needed to justify  
4 rehabilitation benefits, whether Defendant ever granted the benefits, and whether she could appeal.  
5 Defendant ignored her questions for a month, then reiterated its conclusion that she was not entitled  
6 to benefits. The duty to investigate is not suspended by the initial denial of the claim (nor by  
7 filing of suit). Defendant's continued failure to investigate also gives rise to bad faith liability.

8 Jordan v. Allstate Ins. Co. (2007) 148 Cal. App. 4th 1062, 1076.

9 Defendant's purported reason for denying the rehabilitation benefits - that Plaintiff did  
10 not provide information of exactly the sort it wanted - also gives rise to bad faith liability.

11 McCormick v. Sentinel Life Ins. Co. (1984) 153 Cal. App. 3d 1030, 1046 (insurer does not have  
12 the right to insist that the claim be proved only through certain types of evidence). Defendant also  
13 committed bad faith when it failed to respond to Plaintiff's request to appeal the denial of benefits.

14 Shade Foods, Inc. v. Innovative Products Sales & Marketing, Inc. supra at 880.

15 Defendant also breached its duty of good faith and fair dealing when it improperly  
16 terminated benefits in March 2006. Defendant testified that its business practice is always to cut  
17 off monthly disability benefits in accordance with the prognosis in the initial Attending Physician  
18 Statement, without inquiry to the doctor, the insured or the employer. This business practice has  
19 been illegal in California for decades. Miller v. National American Life Ins. Co. of Calif. (1976)  
20 54 Cal. App. 3d 331, 339-340. Defendant's belated suggestion in the moving papers that it cut off  
21 Plaintiff's benefits because it needed to perform further investigation is just untrue. Defendant did  
22 not make a decision to perform a further investigation before cutting off benefits. It automatically  
23 cut off the benefits.

24 Defendant continued to withhold monthly benefits from Plaintiff from March until  
25 July 2006. Even if Defendant had possessed a valid reason for cutting off benefits in March, its  
26 delay in reinstating benefits until July is an unreasonable and bad faith delay. California law  
27 requires insurers to process claims withing 40 days. 10 Cal. Code of Regs. §2695.7. Even absent  
28 the regulation, Defendant would be in bad faith if it unreasonably delayed processing the claim.

1 See, e.g., Cardiner v. Provident Life & Accident Ins. Co., 158 F. Supp.2d 1088, 1099 (C.D. Cal.  
2 2001); Love v. Fire Ins. Exch., 221 Cal. App.3d 1136, 1148 (1990). The evidence shows that  
3 Defendant sat on the claim for weeks without processing it, ultimately reinstating Plaintiff's  
4 benefits in July based on information it had possessed for two months.

5 When Defendant finally did resume the monthly disability payments, it made the  
6 payments three months in arrears. This violated California law which requires that benefits be paid  
7 current. Ins. Code § 10350.8. It also violated the clear terms of the insurance policies.  
8 Defendant continued to violate this law and the terms of the policy every month thereafter until  
9 April 2008. For a year and a half it sent EOBs that showed that it was paying in arrears, and  
10 thereafter it provided Plaintiff with EOBs stating that it was paying current, although it was still  
11 paying in arrears. It ignored the claim in the Complaint that it was paying in arrears. Defendant  
12 ignored the claim in the Joint Case Management Statement that it was paying in arrears. Finally,  
13 after the close of discovery and shortly before filing this motion, Defendant paid the three months  
14 of benefits it had been withholding. Thus, Defendant has finally acknowledged that its conduct of  
15 paying in arrears was improper.

16 Because Defendant obviously committed bad faith in connection with its failure to pay  
17 benefits current, Plaintiff is entitled to fees under Brandt v. Superior Court (1985) 37 Cal.3d 813.  
18 See also Cassim v. Allstate Ins. Co. (2004) 33 Cal.4th 780; Essex Ins. Co. v. Five Star Dye  
19 House, Inc. (2006) 38 Cal. 4th 1252. Plaintiff has incurred attorney fees in connection with the  
20 recovery of the past due benefits and therefore is entitled to recover Brandt fees.

21 A bad faith disregard of its duties to its insureds permeates Defendant's handling of  
22 this claim. It failed to locate all of the insurance policies under which Plaintiff was insured, in  
23 spite of Plaintiff's inquiries, resulting in a ten month delay in a portion of Plaintiff's benefits. It  
24 misrepresented to Plaintiff that it was paying all of the benefits to which Plaintiff was entitled. The  
25 claims department is staffed by untrained and unsupervised personnel, who are not provided with  
26 written policies and procedures for handling claims of the sort presented here. It improperly  
27 withdrew a year's premiums from Plaintiff's bank account. It unreasonable failed to properly  
28 account for premium refunds (see Johnson v. Mutual Benefit Life Ins. Co. (9th Cir. 1988) 847

1 F.2d 600, 603), it paid benefits in the wrong amount, and provided confusing explanations of  
2 refunds and benefit payments. It unreasonably required Plaintiff to travel more than 100 miles for  
3 a medical examination, in violation of Defendant's standard practices, immediately after Plaintiff  
4 complained about Defendant to the Department of Insurance and the District Attorney. Everything  
5 Defendant did on this claim reeks of a conscious disregard for Plaintiff's rights and the rights of  
6 policyholders in general.

7 There is sufficient evidence to overrule the Motion as to the Causes of Action for  
8 fraud and negligent misrepresentation. A case directly on point is Miller v. National American  
9 Life Ins. Co. of Calif. (1976) 54 Cal. App. 3d 331. In Miller, the Court of Appeals upheld a  
10 fraud judgment against an insurance company based upon representations that the company would  
11 make the payments described in policy. Id at 338. Here, Plaintiff points to representations both  
12 within and outside of the policies, which not only represented that policy benefits would be paid,  
13 but also represented that Defendant would treat Plaintiff well and that in the event of a claim,  
14 Defendant was "there to serve" Plaintiff and that her "satisfaction was very important to"  
15 Defendant, and that if she should make a claim, Defendant "fully expect(s) to provide a fair  
16 settlement in a timely fashion."

17 As here, Miller involved a case in which the insurer automatically cut off benefits  
18 based solely on the Attending Physician Statement, without investigation. The Miller Court stated:

19 "The wording of the questions, the policy of interpretation without warning or  
20 guidance to the attending physician, and the failure to consult the doctor as to an  
21 acknowledged uncertainty all lend support to the inference of an intent not to live up  
22 to the promised coverage." Id at 339.

23 The facts here are far more egregious than those presented in Miller. Not only did  
24 Pan American cut off monthly disability benefits without investigation, when it came to the  
25 rehabilitation benefit, it engaged in business practices that assure that it never pays rehabilitation  
26 benefits, that stifle inquiries from claimants about policy benefits, and that, in general, defeat the  
27 purpose for which policyholders purchase these policies.

28 The fact that Pan American designed its business to thwart the reasonable expectations

1 of policyholders demonstrates the falsity of the representations that it made both within and outside  
 2 of the policies. It is hard to imagine a clearer example of misrepresentation in the insurance  
 3 context.

4 The Complaint states a cause of action for violation of the Unfair Competition Law  
 5 (Cal. Bus. & Prof. Code §17200 et. seq.). Substantial evidence supports this theory.

6 The Unfair Competition Law ("UCL") prohibits "any unlawful, unfair or fraudulent  
 7 business act or practice and unfair, deceptive, untrue or misleading advertising . . . ." The section  
 8 demonstrates a clear design to protect consumers as well as competitors. Consumers need the  
 9 greatest protection from sharp business practices. People ex rel. Bill Lockyer v. Fremont Life Ins.  
 10 Co. (2002) 104 Cal. App. 4th 508, 514-515. The UCL is broad enough to reach practically any  
 11 form of predatory business practice in whatever context it may occur. Korea Supply Co. v.  
 12 Lockheed Martin Corp. (2003) 29 Cal. 4th 1134, 1143. Plaintiff is not required to demonstrate a  
 13 series of ongoing wrongful acts. Rather, a single wrongful act is sufficient to establish a violation  
 14 of §17200. Klein v. Earth Elements (1997) 59 Cal. App. 4th 965, 968.

15 The UCL applies to anything that can properly be called a business practice and at the  
 16 same time is forbidden by law. Barquis v. Merchants Collection Ass'n of Oakland, Inc. (1972) 7  
 17 Cal. 3d 94, 113. A business practice that violates any law - civil or criminal, state or federal -  
 18 may be enjoined under this statute. AICCO, Inc. v. Insurance Co. of North America (2001) 90  
 19 Cal. App. 4th 579, 588-589. The statute also applies to acts that are unfair. "Unfair" practices  
 20 are those practices whose harm to the victim outweighs its benefits. Progressive West Ins. Co. v.  
 21 Superior Court (2005) 135 Cal. App. 4th 263, 285-286.

22 Courts have not been hesitant to apply the UCL to insurance claims practices. See,  
 23 e.g., Kapsimallis v. Allstate Ins. Co. (2002) 104 Cal. App. 4th 667, 676 (carrier used date of  
 24 earthquake as date of loss in all cases, without investigation into actual claim, resulting in improper  
 25 denial of claims on statute of limitations basis); Progressive West Ins. Co. v. Superior Court,  
 26 *supra* (the insurance company had a pattern and practice of demanding 100 percent of any moneys  
 27 it paid out to its policyholders under the medical-payments coverage without regard to the  
 28 company's obligations under the made-whole rule or the common-fund doctrine); Ticconi v. Blue

1 Shield of California Life & Health Ins. Co. (2008)160 Cal. App. 4th 528 (the insurer engaged in a  
 2 practice of post-claims underwriting to rescind policies and deny claims). In R & B Auto Center,  
 3 Inc. v. Farmers Group, Inc. (2006) 140 Cal. App. 4th 327, the insurance company sold the insured  
 4 car dealership insurance that the insured reasonably believed would cover it for lemon law  
 5 violations. Plaintiffs alleged that Defendant never intended to actually provide the coverage and  
 6 sought equitable relief under the UCL. The court found that the UCL applied under those facts.  
 7 Id at 355-356.

8 The evidence presented here shows that Pan American engaged in rampant and  
 9 egregious unlawful and unfair conduct that the Court should enjoin. As in R & B Auto Center,  
 10 *supra*, Defendant sells a benefit (the rehabilitation benefit) that it has no intention of actually  
 11 providing. A reasonable consumer reading the policy would expect that rehabilitation benefits  
 12 were available, but in fact, Defendant never pays those benefits. It has no policies in place for  
 13 providing those benefits, it does not honor its legal obligation to tell policyholders about the benefit  
 14 when it appears they might be entitled to it, it denies the benefits without explanation, it refuses to  
 15 respond to inquiries from the policyholder about the benefits, it has no appeal process in place and  
 16 does not answer questions about appeal, and, if the policyholder is insistent about the rehabilitation  
 17 benefit, Defendant misrepresents how claims for this benefit are processed. An insurance company  
 18 cannot be any more unfair than Defendant.

19 No more is needed to deny the Motion for Partial Summary Judgment as to the UCL  
 20 claim, but more is present. In addition to its fraudulent and unfair practice in connection with the  
 21 rehabilitation benefit, there is Defendant's business practice of automatically denying benefits  
 22 based on the initial Attending Physician Statement, without any investigation at all. As discussed  
 23 at some length above, this practice is fraud per se. Miller v. National American Life Ins. Co. of  
 24 Calif. (1976) 54 Cal. App. 3d 331. The UCL is California's answer to the problem of how to deal  
 25 with a business practice like this one.

26 Another illegal practice engaged in by Defendant is paying disability benefits in  
 27 arrears. This practice is made illegal by Ins. Code § 10350.8. Defendant has violated this law  
 28 frequently.

1           There is substantial evidence which Supports the Claim for Intentional Infliction of  
 2 Emotional Distress. Under California law, the elements of a claim for intentional infliction of  
 3 emotional distress (IIED) are: (1) extreme and outrageous conduct by the defendant with the  
 4 intention of causing, or reckless disregard of the probability of causing, emotional distress; (2) the  
 5 plaintiff's suffering severe or extreme emotional distress; and (3) actual and proximate causation of  
 6 the emotional distress by the defendant's outrageous conduct. Christensen v. Superior Court, 54  
 7 Cal.3d 868, 903, (1991)

8           Defendant committed a series of acts, any one of which would be sufficient to allow  
 9 Plaintiff's IIED claim to go the jury. It underpaid benefits, it cut off benefits without basis or  
 10 investigation, it improperly seized funds from Plaintiff's bank account, it paid benefits in arrears, it  
 11 refused to provide the rehabilitation benefit, it refused to answer Plaintiff's questions, it improperly  
 12 calculated refunds, it failed to honor its obligation to waive premiums, it provided  
 13 incomprehensible and confusing accounting, it wrote insulting letters, and so on. California case  
 14 law provides examples of IIED claims against an insurance company for threatened and actual bad  
 15 faith refusals to make payments under the policy. Fletcher v. Western Natl. Life Ins. Co., 10 Cal.  
 16 App.3d 376 (1970) (an insurer's intentional conduct and wanton and reckless disregard of  
 17 consequences to plaintiff in delaying payments of approved benefits vital to the support of plaintiff  
 18 and her children supported an IIED claim). See also Hernandez v. General Adjustment Bureau,  
 19 199 Cal. App.3d 999 (1988).

20           Defendant caused Plaintiff serious emotional upset on several occasions. Defendant  
 21 should expect this sort of strong emotional response from a person who has recently become  
 22 disabled, who is now being denied the lifeline she was depending upon, and who is being treated as  
 23 outrageously as Defendant treated Plaintiff here.

24           Plaintiff's claim for negligent infliction of emotional distress claim is presented under  
 25 the "direct victim" theory. Burgess v. Superior Court, 2 Cal.4th 1064, 1071 (1992). In Marlene F.  
 26 v. Affiliated Psychiatric Medical Clinic, Inc. 48 Cal.3d 583 (1989), the court stated that damages  
 27 for emotional distress are recoverable "when they result from the breach of a duty owed the  
 28 plaintiff that is assumed by the defendant or imposed on the defendant as a matter of law, or that

1 arises out of a relationship between the two." Id. at 590. "Unless the defendant has assumed a duty  
2 to plaintiff in which the emotional condition of the plaintiff is an object, recovery is available only  
3 if the emotional distress arises out of the defendant's breach of some other legal duty and the  
4 emotional distress is proximately caused by that breach of duty." Potter v. Firestone Tire and  
5 Rubber, 6 Cal. 4th 965, 985 (1997); Erlich v. Menezes, 21 Cal.4th 543, 555 (1999). A legal duty  
6 "may be imposed by law, be assumed by the defendant, or exist by virtue of a special  
7 relationship." Potter, supra, 6 Cal.4th at 985; Marlene F., supra, 48 Cal.3d at 590.

8 Defendant argues that Plaintiff cannot establish the requisite duty on behalf of  
9 Defendant to support the tort of negligent infliction of emotional distress. California law does not  
10 support Defendant's argument. In Johnson v. Mutual Ben. Life Ins. Co., 847 F.2d 600 (9th Cir.  
11 1988), a Ninth Circuit court decision where an insured brought an NIED claim against the insurer  
12 as well as a claim for breach of the implied covenant of good faith and fair dealing, the court held  
13 that genuine issues of material fact existed on both claims to preclude summary judgment. In  
14 insurance litigation suits, an action for negligent infliction of emotional distress can be maintained  
15 so long as there is a duty of good faith and fair dealing. Coleman v. Republic Indem. Ins. Co. of  
16 Calif., 132 Cal. App.4th 403, 415-16 (2005). Here, there is very clearly a duty of good faith and  
17 fair dealing, as well as several obvious breaches of that duty. Since a duty exists, the negligent  
18 infliction claim must survive this motion and go to the jury.

19 There is clear and convincing evidence to support the award of punitive damages.  
20 Punitive damages are made available to discourage the perpetuation of objectionable corporate  
21 policies that breach the public's trust and sacrifice the interests of the vulnerable for commercial  
22 gain. Amadeo v. Principal Mut. Life Ins. Co., 290 F.3d 1152, 1164-1165 (9th Cir. 2002)  
23 (reversing a grant of summary judgment and remanding for further proceedings on an insured's  
24 claim for punitive damages, finding sufficient evidence that the denial of her claim "was not simply  
25 the unfortunate result of poor judgment" to allow a jury to conclude that the insurer's actions were  
26 willful and "rooted in established company practice"), quoting Egan, supra, 24 Cal.3d at 820.

27 Punitive damages are available when the insured proves by clear and convincing  
28 evidence that the insurance company engaged in conduct that is oppressive, fraudulent, or

malicious. Amadeo, 290 F.3d at 1164, quoting PPG Industries, Inc. v. Transamerica Ins. Co., 20 Cal.4th 310, 318-319 (1999).

"[A] plaintiff may meet the state of mind requirement for an award of punitive damages by showing that the insurer's bad faith was 'part of a conscious course of conduct, firmly grounded in established company policy.'" Amadeo, 290 F.3d at 1165, quoting Neal v. Farmers Ins. Exchange, 21 Cal.3d 910 (1978).

Pan American has engaged in conduct that is fraudulent, oppressive and malicious as defined by California Civil Code section 3294.

Fraudulent conduct sufficient to support punitive damages is evident both in Defendant's business policy of cutting off benefits without investigation and in its business policy of refusing to pay rehabilitation benefits. In Miller v. National American Life Ins. Co. of Calif., supra, the Court upheld the award of punitive damages based solely on the fraudulent conduct of the insurer that flows from business practice of cutting off benefits without investigation. Here, the fraudulent conduct of the insurer goes far beyond that found in Miller. Not only does the insurer cut off benefits without investigation, it never pay one class of rehabilitation benefits at all, never investigates claims for that type of benefit, stonewalls when a claimant inquires about the benefit, and even makes misrepresentations to the claimant if the claimant insists on a response.

Besides being fraudulent, the conduct of Defendant was malicious and/or oppressive. Conduct is considered malicious if it is either intended by a defendant to cause injury or if it is despicable conduct which is carried on by the defendant with a willful and conscious disregard of the rights of others. Cal. Civil Code §3294(c)(1). It is not necessary to show that Defendant had personal animosity toward plaintiff or acted out of "evil" motives. It is enough that Defendant intended the consequences that were substantially certain to result from its conduct. Schroeder v. Auto Driveway Co. (1974) supra at 922.

Conduct is considered oppressive when it is despicable conduct that subjects a person to cruel and unjust hardship in conscious disregard of that person's rights. Civil Code §3294(c)(2).

Malicious and oppressive conduct is shown here by the following:

- Pan American placed a claims representative with no experience at all in disability

1 claims in sole control of all disability claims;

- 2 • Pan American has no written policies at all regarding the handling of disability
- 3 claims;
- 4 • Pan American did not locate all of the monthly disability benefits it was supposed
- 5 to pay Plaintiff until ten months after the date of disability, and after Plaintiff
- 6 contacted Pan American's billing department to find out why it was still collecting
- 7 premiums;
- 8 • Pan American terminated Plaintiff's monthly disability benefits without
- 9 investigation;
- 10 • Pan American required Ms. Mathews to travel over 100 miles for a medical
- 11 examination immediately after Ms. Mathews complained to the Department of
- 12 Insurance;
- 13 • Pan American withdrew twelve months' premiums from Plaintiff's bank account;
- 14 • Pan American withheld Plaintiff's monthly benefits for two months after it
- 15 completed its investigation into her disability;
- 16 • When Pan American restarted Plaintiff's benefits in July 2006, it paid her 90 days
- 17 in arrears;
- 18 • Defendant wrote to Plaintiff in July 2006 indicating that Plaintiff had only been
- 19 insured for two years, that her application was being investigated and that
- 20 Defendant might seek a judgment against Plaintiff;
- 21 • Pan American refused to pay rehabilitation benefits without explanation;
- 22 • Pan American denied Plaintiff's claim for rehabilitation when it knew that it did
- 23 not have sufficient information to deny that claim;
- 24 • Pan American refused to investigate whether Plaintiff was entitled to rehabilitation
- 25 benefits;
- 26 • Pan American refused to answer Plaintiff's questions about what information was
- 27 needed to provide rehabilitation benefits;
- 28 • Pan American told Plaintiff that rehabilitation benefits were not an "entitlement"

1 when in truth Plaintiff was entitled to the benefit;

- 2 • Pan American told Plaintiff that it used vocational rehabilitation specialists to
- 3 assess rehabilitation claims although it does not do that and its senior officer for
- 4 claims does not even know what a vocational rehabilitation specialist is;
- 5 • Pan American did not properly account to Plaintiff for benefits and refunds of
- 6 premium, but instead repeatedly sent Plaintiff incomprehensible and erroneous
- 7 information;
- 8 • Pan American sent Plaintiff Explanations of Benefits that falsely represented that
- 9 she was being paid current, when in fact she was being paid in arrears.

10 There is clear and convincing evidence of each and every one of these items.

11 The moving papers have not raised the issue of corporate liability for the fraudulent,  
12 malicious and oppressive conduct here. The evidence that Pan American is liable in punitive  
13 damages for such conduct by its employees is abundant here. Not only was everything that was  
14 done here by Mr. Jones supervised by Mr. Simon, the company's Chief Claim Officer (Simon  
15 Depo 6:1), Plaintiff's claim was reviewed by Mr. Simon, together with Pan American's Vice  
16 President for Administration and a lawyer from Pan American's office of in-house counsel, and the  
17 wrongful activity that is the subject of this lawsuit was explicitly ratified

18 **IV. CONCLUSION**

19 Based on the foregoing, Defendant's motion is denied in its entirety.

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21  
22 Saundra B. Armstrong  
Judge  
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